MODEL MANAGED CARE CIVIL STATUTES

National Association of Medicaid Fraud Control Units

March, 2000

Preamble

More Medicaid programs are moving from a predominantly fee-for-service system to a managed care or capitated model. This presents a challenge for state Medicaid Fraud Control efforts. Although the 50 states vary in the manner by which they are introducing managed care into their Medicaid programs, more than 53.64% (as of June 1998) of the nation's Medicaid recipients were in managed care programs, and the percentage is increasing rapidly. The universally expressed concern of the states having managed care experience is that fraud and abuse in managed care has resulted in a decreased quality of services to the recipients (underutilization), and loss of integrity in both the program and contracting providers (bribery and graft). It has become painfully apparent that managed care cannot and will not eliminate fraud and abuse in the health care system and precautions must be built into the system.

Medicaid fraud in a fee-for-service climate has traditionally involved violations punishable by false claims statutes , such as submitting claims for services that were either not rendered or not necessary. In a capitated structure, however, providers do not submit service-specific claims. Providers will be paid a fee which will not vary regardless of the number of services rendered. Unscrupulous providers will defraud the program by providing as few services as possible, or by treating only the healthier patients, thereby allowing the provider to keep more of the capitated fee. Even where the adequacy of care is policed by requiring providers to maintain records of their encounters with patients, the submission of false encounter data, although devastating to the program's quality assurance goals, may not be subject to prosecution under a traditional false claims theory.

The National Association of Medicaid Fraud Control Units adopted this model civil legislation in March 2000 to assist the states in addressing these issues. The purpose of these statutes is to provide a framework for civil administrative or injunctive remedies for dealing with fraud in managed care. In considering the adoption of any or all of the proposed model, states should examine their respective existing laws with regard to false claims, false statements, unfair competition, unfair business and deceptive trade practices and antitrust to determine whether new laws are needed.

I. Managed Care False Claims Actions

(A) Definitions

For purposes of this article:

(1) "Claim" includes:

(a) any request or demand for money, property or services made to any employee, officer, or agent of the state, or to any contractor, subcontractor, grantee or other recipient, whether under contract or not; and,

(b) any documentation submitted to any employee, officer, or agent of the state, or to any contractor, subcontractor, grantee or other recipient, whether under contract or not, in whatever form, which is designed to allow the retention of money, property or services previously paid, given or delivered by the state or by any subdivision thereof; and,

(c) any documentation which is required to be kept and maintained , in whatever form, which is designed to allow the retention of money, property or services previously paid, given or delivered by the state or by any subdivision thereof, if any portion of the money, property or services is requested or demanded from, or was provided by a managed care program operated or funded by the state or by any subdivision thereof.

(2) "Knowing" and "knowingly" mean that a person, with respect to information, does any of the following:

(a) Has or should have actual knowledge of the information.
(b) Acts in deliberate ignorance of the truth or falsity of the information.
(c) Acts in reckless disregard of the truth or falsity of the information.

Proof of specific intent to defraud is not required.

(3) "Political subdivision" ...

(4) "Prosecuting authority" ...

(5) "Person" includes any natural person, corporation, professional corporation, firm, association, organization, partnership, business, limited liability company, trust or any other legal entity.

(6) "Managed care program" means.....

(7) "Recipient" means .....

(B) Liability for Certain Acts

Any person who commits any of the following acts shall be liable to the state or political subdivision for a civil penalty of up to $10,000 per claim, for treble the amount of damages the state

sustains because of the act or omission of that person, and for the costs of a civil action brought to recover any of those penalties or damages.

(1) Knowingly presents or causes to be presented a false or fraudulent claim for payment or approval for payment knowing that all or a portion of the payment for the claim would issue from or be paid with funds provided by a managed care program operated or funded by the state or any political subdivision thereof;

(2) Knowingly makes, uses or causes to be made or used a false record, datum, or statement to obtain payment or approval for payment knowing that all or a portion of the claim would be paid with funds issued from or provided by a managed care program operated or funded by the state or any political subdivision thereof.

(3) Conspires to defraud the state or any political subdivision thereof by obtaining payment or approval for payment of a false claim, knowing that all or a portion of the claim would be paid with funds issued from or provided by a managed care program operated or funded by the state or any political subdivision thereof;

(4) Having possession, custody, or control of property or money issued from or provided by a managed care program operated or funded by the state or any political subdivision thereof for the provision of medical services, knowingly delivers or causes to be delivered less goods, services, or treatment than the person certifies or claims were provided or which are less than contractually required or mandated.

(5) Is required to make or deliver a document certifying receipt of property or money issued from or provided by the state or any political subdivision thereof for services provided in a managed care program and Knowingly makes or delivers a receipt documentation that falsely represents the number, type or amount of goods, services or treatment provided, or the number or classification of recipients for whom the services are claimed to have been provided or otherwise presents false data on the completed in a managed care program operated or funded by the state or any political subdivision thereof.

(6) Knowingly makes, uses, or causes to be made or used a false record or statement in a managed care program in order to to conceal, avoid, or decrease an obligation to pay or transmit money or property knowing that the money, or property or services is are wholly or partially derived from the a managed care program operated or funded by the state or any political subdivision thereof.

(7) As a participant in a managed care program is a beneficiary of an inadvertent submission of a false claim any portion of which would issue from or be paid by the state or any political subdivision thereof, subsequently discovers the falsity of the claim, and knowingly fails to disclose the false claim to the state or political subdivision within a reasonable time after discovery of the false claim.

(8) Knowingly submits or causes to be submitted a claim in a managed care program knowing that a recipient has been denied service or received a lesser degree of service than was

certified as being provided and knowing that a portion of the claim would be paid by the state or any political subdivision thereof.

(C) Injunctive Relief

Any person who engages, has engaged or proposes to engage in any act described by section I.(B) may be enjoined in any court of competent jurisdiction in an action brought by the Attorney General; such action shall be brought in the name of the state. The court may make such orders or judgments, including the appointment of a receiver, as may be necessary to prevent any act described by section I.(B) by any person, or as may be necessary to restore to any person in interest any money or property, real or personal, which may have been acquired by means of such act.

Commentary

Anticipated coverage: The act establishes a civil penalty for certain types of activities of all parties within the managed care environment. Recognizing that certain payments the act seeks to regulate, within such a format are pre-paid, the act would expand the common usage of the term "claim" to encompass, not only requests or demands for money, property or other services, but to cover documentation of any type which would allow the retention of money, property, or other services and any documentation that is required to be kept in order to allow the retention of money, property or other services, which have previously been paid, given or performed. It establishes a civil penalty in a Medicaid managed care program for knowingly (1) presenting false documents, (2) making false records, (3) conspiracy to defraud, (4) retaining monies to which the person is not entitled, (5) making or delivering false documentation, (6) making or using false documentation of avoid financial obligations, (7) failing to disclose the inadvertent receipt of monies obtained as a result of a fraudulent claim, and (8) presenting a claim for which service has been denied or which overstates the services that were provided. In addition providing a civil penalty for violations of the act, the proposed statute would allow for the grant of injunctive relief to prevent continuing violations of the act.

Notes: Subsections I.(A)(1)(a), (b) and (c) of the proposed statute are based on a belief that a managed care environment, vendors may be prepaid for goods and services to be rendered in the future. As a result, it is necessary to regulate a vendor's entitlement to the retention of these sums.

Subsection (2) track the definitions of the terms "knowing" and "knowingly" which are found in the False Claims Act, 31 U.S.C. §3729(b).

Subsections (3), (4), (6) and (7) allow individual states to tailor the definitions necessary for the implementation of the statute to each state's unique situation.

Subsection (5) utilizes an expansive definition of the term "person" to encompass all types of natural and corporate entities that do business in a managed care environment.

Sections I.(B) (1-8) track, to the extent possible, the language of the False Claims Act, 31 U.S.C. § 3729, while retaining the unique prohibitions necessary for enforcement of the statute in a managed care setting.

Section I.(C) provides a generic right to seek injunctive relief for violations of the type prohibited by Section I.(B).

II. Limitation on referrals

(A) Definitions

In this subtitle the following words have the meanings indicated.

(1) The term "beneficial interest" means ownership, through equity, debt, or other means, of any financial interest. "Beneficial interest" does not include ownership, through equity, debt, or other means, of securities, including shares or bonds, debentures, or other debt instruments:

(a) In a corporation that is traded on a national exchange or over the counter on the national market system;

(b) That at the time of acquisition, were purchased at the same price and on the same terms generally available to the public;

(c) That are available to individuals who are not in a position to refer patients to the health care entity on the same terms that are offered to health care practitioners who may refer patients to the health care entity;

(d) That are unrelated to the past or expected volume of referrals from the health care practitioner to the health care entity; and

(e) That are not marketed differently to health care practitioners that may make referrals than they are marketed to other individuals.

(2) The term "compensation arrangement" means any agreement or system involving any remuneration between a health care practitioner or the immediate family member of the health care practitioner and a health care entity.

(a) "Compensation arrangement" does not include:

(i) Compensation or shares under a faculty practice plan or a professional corporation affiliated with a teaching hospital and comprised of health care practitioners who are members of the faculty of a university;

(ii) Amounts paid under a bona fide employment agreement between a health care entity and a health care practitioner or an immediate family member of the health care practitioner;

(iii) An arrangement between a health care entity and a health care practitioner or the immediate family member of a health care practitioner for the provision of any services, as an independent contractor, if:

(1) The arrangement is for identifiable services;

(2) The amount of the remuneration under the arrangement is consistent with the fair market value of the service and is not determined in a manner that takes into account, directly or indirectly, the volume or value of any referrals by the referring health care practitioner; and

(3) The compensation is provided in accordance with an agreement that would be commercially reasonable even if no referrals were made to the health care provider;

(iv) Compensation for health care services pursuant to a referral from a health care practitioner and rendered by a health care entity, that employs or contracts with an immediate family member of the health care practitioner, in which the immediate family member's compensation is not based on the referral;

(v) An arrangement for compensation which is provided by a health care entity to a health care practitioner or the immediate family member of the health care practitioner to induce the health care practitioner or the immediate family member of the health care practitioner to relocate to the geographic area served by the health care entity in order to be a member of the medical staff of a hospital, if:

(1) The health care practitioner or the immediate family member of the health care practitioner is not required to refer patients to the health care entity;

(2) The amount of the compensation under the arrangement is not determined in a manner that takes into account, directly or indirectly, the volume or value of any referrals by the referring health care practitioner; and

(3) The health care entity needs the services of the practitioner to meet community health care needs and has had difficulty in recruiting a practitioner; or

(A) Testing, diagnosis, or treatment of human disease or dysfunction; or

(B) Dispensing of drugs, medical devices, medical appliances, or medical goods for the treatment of human disease or dysfunction.

(8) The term "health care service" means any health care procedure, service or good provided to a patient by or through a health care entity.

(9) The term "immediate family member" means a health care practitioner's:

(A) Spouse;
(B) Child;
(C) Child's spouse;
(D) Parent;
(E) Spouse's parent;
(F) Sibling; or
(G) Sibling's spouse.

(10) The term "in-office ancillary services" means those basic health care services and tests routinely performed in the office of one or more health care practitioners.

(A) Except for a radiologist group practice or an office consisting solely of one or more radiologists, "in-office ancillary services" does not include:

(i) Magnetic resonance imaging services;
(ii) Radiation therapy services; or
(iii) Computer tomography scan services.

(11) The term "referral" means any referral of a patient for health care services.

(A) "Referral" includes:

(i) The forwarding of a patient by one health care practitioner to another health care practitioner or to a health care entity outside the health care practitioner's office or group practice; or

(ii) The request or establishment by a health care practitioner of a plan of care for the provision of health care services outside the health care practitioner's office or group practice.

(B) Prohibited Referrals; Exceptions; Disclosures

(1) Except as provided in paragraph (4), a health care practitioner may not refer a patient, or direct an employee of or person under contract with the health care practitioner to refer a patient to a health care entity:

(a) In which the health care practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family owns a beneficial interest; or

(b) With which the health care practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family has a compensation arrangement.

(2) A health care entity or a referring health care practitioner may not present or cause to be presented to any individual, third party payor, or other person a claim, bill, or other demand for payment for health care services provided as a result of a referral prohibited by this section.

(3) Paragraph (1) applies to any arrangement or scheme, including a cross-referral arrangement, which the health care practitioner knows or should know has a principal purpose of assuring indirect referrals that would be in violation of paragraph (1) if made directly.

(4) The provisions of this subsection do not apply to:

(a) A health care practitioner who refers a member of a health maintenance organization to a health care entity outside the health care practitioner's office or group practice when the referral is made pursuant to a contract with the health maintenance organization;

(b) A health care practitioner who refers a patient to another health care practitioner in the same group practice as the referring health care practitioner;

(c) A health care practitioner with a beneficial interest in a health care entity who refers a patient to that health care entity for health care services or tests, if the services or tests are personally performed by or under the direct supervision of the referring health care practitioner;

(d) A health care practitioner who refers in-office ancillary services or tests that are:

(i) Personally furnished by:

(1) The referring health care practitioner;

(2) A health care practitioner in the same group practice as the referring health care practitioner; or

(3) An individual who is employed and personally supervised by the referring health care practitioner or a health care practitioner in the same group practice as the referring health care practitioner;

(ii) Provided in the same building where the referring health care practitioner or a health care practitioner in the same group practice as the referring health care practitioner furnishes services; and

(iii) Billed by:

(1) The health care practitioner performing or supervising the services; or

(2) A group practice of which the health care practitioner performing or supervising the services is a member;

(e) A health care practitioner who has a beneficial interest in a health care entity if, in accordance with regulations adopted by the Secretary:

(i) The Secretary determines that the health care practitioner's beneficial interest is essential to finance the health care entity; and

(ii) The Secretary determines that the health care entity is needed to ensure appropriate access for the community to the services provided at the health care entity;

(f) A health care practitioner employed or affiliated with a hospital, who refers a patient to a health care entity that is owned or controlled by a hospital or under common ownership or control with a hospital if the health care practitioner does not have a direct beneficial interest in the health care entity;

(g) A health care practitioner or member of a single specialty group practice, including any person employed or affiliated with a hospital, who has a beneficial interest in a health care entity that is owned or controlled by a hospital or under common ownership or control with a hospital if:

(i) The health care practitioner or other member of that single specialty group practice provides the health care services to a patient pursuant to a referral or in accordance with a consultation requested by another health care practitioner who does not have a beneficial interest in the health care entity; or

(ii) The health care practitioner or other member of that single specialty group practice referring a patient to the facility, service, or entity personally performs or supervises the health care service or procedure;

(h) A health care practitioner with a beneficial interest in, or compensation arrangement with, a hospital or a facility, service, or other entity that is owned or controlled by a hospital if:

(i) The beneficial interest was held or the compensation arrangement was in existence on January 1, 1993; and

(ii) Thereafter the beneficial interest or compensation arrangement of the health care practitioner does not increase;

(i) Any other beneficial interest or compensation arrangement which the Secretary determines, and specifies in regulations, does not pose a risk of abuse; or

(j) Any activity which, if engaged in by a physician, would not be prohibited under 42 U.S.C. § 1395nn or regulations promulgated thereunder.

(5) A health care practitioner exempted from the provisions of this subsection in accordance with paragraph (4) shall be subject to the disclosure provisions of subsection (c) of this section.

(C) Disclosure of Beneficial Interest

(1) Except as provided in paragraph 3, a health care practitioner making a lawful referral shall disclose the existence of the beneficial interest in accordance with provisions of this subsection.

(2) Prior to referring a patient to a health care entity in which the practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family owns a beneficial interest, the health care practitioner shall:

(a) Except if an oral referral is made by telephone, provide the patient with a written statement that:

(i) Discloses the existence of the ownership of the beneficial interest or compensation arrangement;

(ii) States that the patient may choose to obtain the health care service from another health care entity; and

(iii) Requires the patient to acknowledge in writing receipt of the statement;

(b) Except if an oral referral is made by telephone, insert in the medical record of the patient a copy of the written acknowledgment;

(c) Place on permanent display a written notice that is in a typeface that is large enough to be easily legible to the average person from a distance of 8 feet and that is in a location that

is plainly visible to the patients of the health care practitioner disclosing all of the health care entities:

(i) In which the practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family owns a beneficial interest; and

(ii) To which the practitioner refers patients; and

(d) Documents in the medical record of the patient that:

(i) A valid medical need exists for the referral; and

(ii) The practitioner has disclosed the existence of the beneficial interest to the patient.

(3) The provisions of this section do not apply to:

(a) A health care practitioner when treating a member of a health maintenance organization pursuant to a contract with a health maintenance organization; or

(b) A health care practitioner who refers a patient:

(i) To another health care practitioner in the same group practice as the referring health care practitioner;

(ii) For in-office ancillary services; or

(iii) For health care services provided through or by a health care entity owned or controlled by a hospital.

(D) Disclosure to Third Party Payors; Reporting Requirements

(1) A health care practitioner shall disclose the name of a referring health care practitioner on each request for payment or bill submitted to a third party payor, including nonprofit health plans and fiscal intermediaries and carriers, that may be responsible for payment, in whole or in part, of the charges for a health care service, if the health care practitioner knows or has reason to believe:

(a) There has been a referral by a health care practitioner; and

(b) The referring health care practitioner has a beneficial interest in or compensation arrangement with the health care entity that is prohibited under subsection (B) of this section.

(2) Each entity providing health care services for which payment may be made under a Medicaid health plan shall provide the Secretary with information concerning the entity's ownership, investment, and compensation arrangements, including:

(a) The health care services provided by the entity, and

(b) The names and unique physician identification numbers, if applicable, of all health care practitioners who own a beneficial interest in the entity or have a compensation arrangement with the entity, or whose immediate family own a beneficial interest in the entity or have a compensation arrangement with the entity. Such information shall be provided in such form, manner, and at such times as the Secretary shall specify. The requirement of this subsection shall not apply to health care services provided outside the State or to entities which the Secretary determines provide services for which payment may be made by a Medicaid health plan very infrequently.

(E) Collections for Services Provided Pursuant to Prohibited Referral

(1) If a referring health care practitioner, a health care entity, or other person furnishing health care services collects any amount of money that was billed in violation of subsection (B) of this section and the referring health care practitioner, health care entity, or other person knew or should have known of the violation, the referring health care practitioner, health care entity, or other person is jointly and severally liable to the payor for any amounts collected and shall refund such amounts on a timely basis.

(2) If a claim, bill or other demand or request for payment for health care services in violation of subsection (B) of this section is denied, or if any amount paid as a result of any such claim is refunded under paragraph (1), the referring health care practitioner, health care entity or other person furnishing the health care services may not submit a claim, bill or other demand or request for payment to the person who received the services.

(F) Sanctions

(1) Any person who:

(a) Makes or causes to be made a referral that any such person knows or should know is prohibited under subsection (B) of this section;

(b) Presents or causes to presented a bill or claim for a service that any such person knows or should know is prohibited by subsections (B) or (E) of this section; or

(c) Fails to make a refund as required by subsection (E) of this section shall be subject to a civil penalty of not more than $15,000 for each such bill, claim or service.

(2) Any person who enters into an arrangement or scheme (such as a cross-referral arrangement) which the person knows or should know has a principal purpose of assuring referrals by a health care practitioner to a particular entity which, if the health care practitioner directly made referrals to such entity, would be in violation subsection (B) of this section, shall be subject to a civil money penalty of not more than $100,000 for each such arrangement or scheme.

(3) Any person who is required, but fails, to meet a reporting or disclosure requirement of subsection (D) of this section is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made.

(4) In any proceeding to impose a civil penalty under this section, the Secretary may make a determination in the same proceeding to exclude the person from participation in the Medicaid health plan.

(5) A violation of this section by a health care practitioner or entity constitutes grounds for disciplinary action by the applicable licensing body.

Commentary

Anticipated Coverage: Prohibits and provides civil penalties for certain referrals to health care entities by health care practitioners who hold a financial stake in the entity. Also prohibits billing for any services rendered as a result of a prohibited referral, and requires the refund of any such amounts billed. Section (C) also requires that a health care practitioner making a permitted referral disclose to the patient the practitioners' interest in the entity to which the patient is referred, and requires health care entities providing services to Medicaid recipients to disclose to the single state agency any beneficial interest or compensation arrangement which health care practitioners have in or with the entity.

Notes: The proposed statute is modeled after state and federal anti-referral statutes including 42 U.S.C. § 1395nn and Md. Health Occ. Code Ann. §§1-301-1-305. The model statute is broader, however, than the federal statute in that it extends *to all health care practitioners who are licenced or certified under state law, whereas the federal statute is limited to physicians.*

Section (B)(4)(a) of the model statute permits referrals of members of health maintenance organizations to entities in which the practitioner has an interest, if the referrals are made pursuant to a contract with the health maintenance organization. Individual states may wish to add other types of managed care organizations to this exemption, or to define "health maintenance organization" by reference to state statutes or otherwise.

As is true with the federal statute and most state statutes, the model statue contemplates regulations to clarify particular situations which do or do not run afoul of the statute. The model also contains a general exemption in section (B)(4)(i) for any arrangements which the single state agency finds do not pose a risk of abuse.

Section (B)(4)(j) exempts from the coverage of the statute any activity which would be permissible under the relevant federal statute and regulations if the activity were engaged in by a physician. This provision, which is similar to provisions contained in a number of state statutes, is included for two reasons. First, it obviates the need for a complete set of regulations in this complex field to the extent that the regulations would duplicate existing federal regulations. Second, it relieves physicians of the necessity of complying with two sets of possibly inconsistent requirements.

III. Civil Monetary Penalties

(A) Definitions

For the purpose of this section:

(1) The term "claim" means an application for payments for items and services under a Medicaid health plan.

(2) The term "Medicaid health plan" means

(a) a State plan established under title XIX of the Social Security act of 1939;

(b) a private health insurance carrier, health maintenance organization, health care cooperative or alliance, or other person that provides or contracts to provide health care goods or services which are reimbursed by or are a required benefit of a plan described in subsection (2)(a); and

(c) a person that provides, contracts, or subcontracts to provide health care goods or services for an entity described in subparagraphs (a) or (b) of this paragraph.

(3) The term "item or service" includes

(a) any particular item, device, medical supply, or service claimed to have been provided to a patient and listed in an itemized claim for payment, and

(b) in the case of a claim based on costs, any entry in the cost report, books of account or other documents supporting such claim.

(4) The term "managing employee " means, with respect to an entity, an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity.

(5) The term "recipient" means an individual who is eligible to receive items or services for which payment may be made under a Medicaid health plan but does not include a provider, supplier, or practitioner.

(6) The term "remuneration" includes transfers of items or services for free or for other than fair market value.

(7) The term "should know" means that a person, with respect to information -

(a) acts in deliberate ignorance of the truth or falsity of the information; or

(b) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

(B) Claims for Excessive Charges or Unnecessary Services; Failure of Certain Persons to Furnish Medically Necessary Services; Improperly Filed Claims

Any person that -

(1) has submitted or caused to be submitted bills or requests for payment (where such bills or requests are based on charges or cost) under a Medicaid health plan containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished substantially in excess of such person's usual charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, without good cause therefor;

(2) has furnished or caused to be furnished items or services to patients (whether or not eligible for benefits under the Medicaid health plan) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care;

(3) is a health maintenance organization providing items and services under a Medicaid health plan and has failed substantially to provide medically necessary items and services that are required under law, regulation or a contract with the State to be provided to individuals covered under a Medicaid health plan, if the failure has adversely affected (or has substantial likelihood of adversely affecting) these individuals; or

(4) fails to disclose such full and complete information as may be required by regulation or contract as the identity and ownership of a subcontractor with whom the person has done business, or as to any significant business transactions between the person and any wholly owned supplier, or between the person and any subcontractor.

(5) engages in practices that reasonably could be expected to discourage enrollment of individuals expected to need substantial future medical services, discriminates against any recipient on the basis of health or for any other reason, expels or refuses to re-enroll a recipient in violation of prescribed regulations or the provisions of its contract with the State,

(6) misrepresents or falsifies information required by law, regulation, or contract with respect to the provision of services under a Medicaid health plan, whether said misrepresentation is communicated to the State, to any other individual or entity that contracts with the State, or to a recipient, or in connection with receiving any certification or approval necessary to become enrolled as a provider of services under a Medicaid health plan.

(7) provides services in connection with a Medicaid health plan without obtaining the necessary license and approval, or provides services during a period when said license or approval has been revoked, suspended, surrendered, or otherwise lost for reasons of professional competence, performance, or financial integrity, or in conjunction with any formal disciplinary proceeding.

(8) solicits, receives, offers, or pays anything of value as an inducement to refer, or to fail to refer, any patient whose care is paid in whole or in part by a Medicaid health plan.

(9) charges any person or governmental agency an amount in excess of established Medicaid health plan rates, or solicits or receives anything of value in excess of Medicaid or Medicaid health plan rates as a condition of admission or continued stay in a hospital or long term care facility.

(10) makes or causes to be made, any material misrepresentation with respect to the nature and extent of services which are covered or must otherwise be provided under the Medicaid health plan, or charging a Medicaid recipient a premium for providing covered services.

(11) is a hospital or long term care facility that refuses to treat or involuntarily discharges a patient for reasons related to insurance or lack thereof, and/or an inability to pay for services rendered, unless:

(a) the patient's medical condition is stable and the release will not endanger the health and safety of the patient,

(b) the patient is being released into an appropriately safe and secure environment, and

(c) the provider has taken reasonable steps to ensure that there is a continuity of care.

(12) knowingly presents or causes to be presented a claim under a Medicaid health plan that the Secretary determines -

(a) is for a medical or other item or service that the person knows or should know was not provided as claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,

(b) is for a medical or other item or service and the person knows or should know the claim is false or fraudulent,

(c) is for a medical or other item or service furnished during a period in which the person was excluded from participating in the Medicaid health plan under which the claim was made pursuant to a determination by the State or the United States, or

(d) is for a pattern of medical or items or services that a person knows or should know are not medically necessary;

(13) in the case of a person who is not an organization, agency, or other entity, is excluded from participation in the Medicaid health plan by the State or the United States and who, at the time of a violation of this subsection -

(a) retains a direct or indirect ownership or control interest in an entity that is participating in the program and who knows or should know of the action constituting the basis for the exclusion; or

(b) is an officer or managing employee of such an entity; or

(14) makes a representation to a Medicaid health plan which the person making the representation knows or should know is materially false or fraudulent.

(15) offers to or transfers remuneration to any individual eligible for benefits under the program that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under the Medicaid health plan;

(16) fails to make available or refuses access to Medicaid-related records to the Secretary, the State, or the Federal Government as required by regulation or statute;

(17) fails to maintain medical records made at the time of service, or prior to service if prior authorization is required, demonstrating the necessity and appropriateness of the goods or services rendered, as required by regulation or statute;

(18) fails to comply with provisions of publications that have been adopted by reference as rules by the Secretary; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the Secretary and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative to the Medicaid health plan, as such provisions apply to the Medicaid health plan;

(19) demonstrates a pattern of failure to provide goods or services that are medically necessary, as required by relevant rules, regulations, statutes or contract with a Medicaid health plan;

(20) knowingly submits or causes to be submitted to a Medicaid health plan a provider enrollment application, a request for prior authorization of services, a drug exception request or a cost report that contains materially false or incorrect information;

(21) knowingly collects from or bills a recipient or a recipient's responsible party for amounts that should not have been so collected or billed by reason of the provider's billing the Medicaid health plan for the same service; shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each item or service; (in cases under paragraph 12), $10,000 for each day the prohibited relationship occurs). In addition, such a person shall be subject to an assessment of not more than three times the amount claimed for each such item or service in lieu of damages sustained by the Medicaid health plan because of such claim. In

addition, the Secretary may make a determination in the same proceeding to exclude the person from participation in the Medicaid health plan.

(C) Initiation of Proceeding; Authorization By Attorney General, Notice, etc.; Estoppel, Failure to Comply With Order Or Procedure

(1) The Secretary shall not make a determination adverse to any person under subsection (B) of this section until the person has been given written notice and an opportunity for the determination to be made on the record after a hearing at which the person is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the person.

(2) In a proceeding under subsection (B) of this section which -

(a) is against a person who has been convicted or found guilty (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a state or federal crime charging fraud or false statements, and

(b) involves the same transaction as in the criminal action, the person is estopped from denying the essential elements of the criminal offense.

(3) The official conducting a hearing under this section may sanction a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an action, or other misconduct as would interfere with the speedy, orderly, or fair conduct of the hearing. Such sanction shall reasonably relate to the severity and nature of the failure or misconduct. Such sanction may include -

(a) in the case of refusal to provide or permit discovery, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established,

(b) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense,

(c) striking pleadings, in whole or in part,

(d) staying the proceedings,

(e) dismissal of the action,

(f) entering a default judgment,

(g) ordering the party or attorney to pay attorneys' fees and other costs caused by the failure or misconduct, and

(h) refusing to consider any motion or other action which is not filed in a timely manner.

(D) Amount or Scope of Penalty, Assessment, or Exclusion

In determining the amount or scope of any penalty, assessment, or exclusion imposed pursuant to subsection (B) of this section, the Secretary shall take into account -

(1) the nature of claims and the circumstances under which they were presented,

(2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims,

(3) the effect, if any, on the health of or quality of medical care rendered to recipients as a result of the acts of the provider, and

(4) such other matters as justice may require.

(E) Finality of Determination Respecting Penalty, Assessment, or Exclusion

A determination by the State to impose a penalty, assessment, or exclusion under subsection (B) of this section shall be final upon the expiration of the period in which an appeal is allowed by law. Matters that were raised or that could have been raised in a hearing before the Secretary regarding a penalty, assessment, or exclusion under subsection (B) of this section may not be raised as a defense to a civil action by the United States to collect a penalty, assessment, or exclusion assessed under this section.

(F) Notification of Appropriate Entities of Finality of Determination

Whenever the Secretary's determination to impose a penalty, assessment, or exclusion under subsection (B) of this section becomes final, he shall notify the appropriate State, federal or local medical or professional organization, the appropriate State or federal agency or agencies administering or supervising the administration of state or federally-funded health plans and the appropriate utilization and quality control peer review organization, and the appropriate State, federal or local licensing agency or organization that such a penalty, assessment, or exclusion has become final and the reasons therefor.

(G) Liability of Principal For Acts of Agent

A principal is liable for penalties, assessments, and an exclusion under this section for the actions of the principal's agent acting within the scope of the agency.

(H) Remedies Cumulative

The remedies under this section are separate from and cumulative to any other administrative, criminal or civil remedies available under federal or state law or regulation.